tant role in treating that disorder in primary care. We demonstrate the cost-effectiveness of Escitalopram for Germany measured by successfully treated patients. **METHODS:** A markov-model over a horizon of 70 days with three markov-stages (remission, partial response, no response) was constructed. Due to the fact that the perspective of the physician was taken, only costs for medication have been considered. In order to include therapeutic decisions of physicians in a naturalistic matter, a survey of 190 GPs and 60 specialists has been conducted. **RESULTS:** Escitalopram has a 30% (GP: 113 vs. 144 €/successfully treated patient, specialist: 123 vs. 163 €/successfully treated patient) more favourable cost-effectiveness ratio compared with Venlafaxin XR. Depending on the setting (GP/Specialist) the incremental cost-effectiveness ratio is considered to be 6800–7400€. The lower costs in the GPs model are due to referrals to specialists, since from the GPs perspective no further costs occur. **CONCLUSIONS:** Escitalopram is a cost-effective alternative to Venlafaxin XR for the treatment of MDD in the German setting.

PMH28

A COST-EFFECTIVENESS ANALYSIS OF ESCITALOPRAM AND SERTRALINE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

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OBJECTIVE: To compare the cost-effectiveness of escitalopram and sertraline for the treatment of depression based upon a head-to-head clinical study and published literature. **METHODS:** A decision analytical model was created based upon data obtained from an eight-week clinical study evaluating escitalopram and sertraline for the treatment of major depressive disorder. The primary outcome of the clinical study was improvement in depressive symptoms as measured by the Montgomery-Asberg Depression Rating Scale. The model was constructed from a payer's perspective with a six-month time horizon. The clinical trial allowed dose titration for sertraline in 50 mg increments. The primary outcome for the model was cost per quality-adjusted life year (QALY). The decision analysis took into account the rate of adverse drug reactions by drug and dose. QALY estimates were assigned to various health states and included depression, adverse events, and treatment failure. Medication costs were obtained from an Internet pharmacy. Costs of adverse events and treatment failure were obtained from published studies. Estimated physician costs were obtained from US Medicare fee schedules. **RESULTS:** The estimated six-month cost was $952 for escitalopram and $1372 for sertraline. The estimated QALYs were 0.403 for escitalopram and 0.393 for sertraline. The cost/QALY for the two agents was $2362 and $3494, respectively. Threshold analyses were conducted to determine variables that influenced the results. The most important variable in the model was the cost of treatment failures. In the primary analysis, the cost of treatment failures was $8141. When this cost was reduced to $5000, the cost/QALY was $1993 and $2808 for escitalopram and sertraline, respectively. **CONCLUSIONS:** The results suggest that escitalopram had a lower cost and resulted in more QALYs. This difference was due mainly to a lower ADR rates for escitalopram and fewer titrations with escitalopram.

PMH29

THE EFFECT OF RAISING THREE TIER COPAYMENTS ON SSRI COMPLIANCE RATES

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OBJECTIVES: 1) To characterize design of drug benefits of SSRI antidepressants in health plans offered by employers in the United States; and 2) To determine the effect of raising copayments on compliance rates of SSRI antidepressants. **METHODS:** Data comprised benefit information and claims from Medstat's MarketScan database for 2000–2003. Benefit information were compiled from approximately 135 different plans. Any patient who filled a prescription SSRI antidepressants in 2000 and was continuously enrolled through 2001 was identified. A difference in difference approach was used to examine the change in the days supplied and number of claims filled for an employer that raised their three tiered co-payments as compared to an employer that kept constant one tier copayment rates. **RESULTS:** Three tier copayment structures were increasingly common among employers. Most SSRIs fall in tier two although some of the newer SSRIs are commonly found in tier three. The average copayment for tier 1 increased from $5.40 to $7.40. The average copayment for tier 2 increased from $13.60 to $16.80. The average copayment for tier 3 increased from $25.40 to $31.20. When the study employer raised their co-payments by 50%, they experienced a 25% decline in the number of prescriptions per person filled (from 5.2 to 3.9 prescriptions) from 2000 to 2001, while the control employer demonstrated a 20% decline (from 6.0 to 4.8) in the number of prescriptions filled. Days supplied fell by 41.3 days or 24% in the employer that raised copayments and by 36.3 days or 17% in the control employer. **CONCLUSIONS:** Benefit structure and co-pays have trended towards 3-tier plans with increasing copayments. As such, increasing copayments may have a negative effect on compliance and possibly outcomes.

PMH30

OUTCOME ANALYSIS OF A MULTI-LEVEL INTERVENTION PROGRAM TO IMPROVE ANTIDEPRESSANT MEDICATION ADHERENCE

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Despite the importance of medication adherence in the management of depression, adherence rates for antidepressant therapy are poor. Failure to adhere to pharmaceutical therapy leads to poor clinical outcomes and increased health care costs. **OBJECTIVE:** To evaluate the impact of an interventional program on antidepressant medication adherence. **METHODS:** This was a prospective interventional program with retrospective adherence study using 24-month pharmacy claims database. Medication adherence measures included length of therapy, median gap, persistence over time, and procession ratio were obtained prior to and at 18 months post implementation of interventions. Physician educational interventions included on-site provider education, review of The Agency for Healthcare Research and Quality (AHRQ) guidelines for major depression, newsletter, and case management. Patient interventions included case managers followed up with non-compliant patients by phone for oral counseling, newsletter, incentive programs, and reminder postcards. **RESULTS:** A total of 4021 patients were included in the study. Significant improvements were observed at post intervention for all adherence parameters. The average length of therapy at outcome measure was 165 days compared to 131 days at baseline. Persistence over time showed 72% of patients completed their acute phase therapy (84 days) compared to 60% at baseline ($p < 0.001$) and 55% of patients continued their continuation therapy (180 days) compared to 46% at baseline ($p < 0.001$). The procession ratio over time at 180 days was 0.8, an improvement of 24% from the baseline. **CONCLUSIONS:** Results of our analysis indicated significant improvements in